

# Bone Density Test

Patient Information	
Full Name	
Date of Birth	
Gender	
Contact Number	
Address	
Medical History & Related Questions	
Known Bone-related Conditions	
Current Medications	
Previous Fractures or Bone Injuries	
Family History of Osteoporosis or Bone Disorders	
Menopause Status (if applicable)	<input type="checkbox"/> Pre-menopausal <input type="checkbox"/> Post-menopausal <input type="checkbox"/> Not Applicable
Calcium and Vitamin D Intake	<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate <input type="checkbox"/> Unsure
Alcohol and Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity Level	<input type="checkbox"/> Sedentary <input type="checkbox"/> Moderate <input type="checkbox"/> Active

<b>Tests Conducted</b>	
<b>Test Site</b>	<input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Hip <input type="checkbox"/> Forearm <input type="checkbox"/> Other
<b>Findings</b>	
<b>Basis for Findings</b>	
<b>T-score</b>	
<b>Z-score</b>	
<b>Interpretation</b>	
<b>T-score Interpretation</b>	
<b>Z-score Interpretation</b>	
<b>Overall Interpretation</b>	
<b>Bone Health Assessment</b>	
<b>Recommendations</b>	